Reset

This form will be scanned electronically.
Please write legibly.

Supplement to the application

Contract no. /

Employer
Name and location

Insured person
Name | First name | Nationality

Street, postal code and location | Date of birth | Gender ☐ m ☐ f

Occupational activities | Country of employment

Can be reached at
Private email address | Phone no.

Height (cm) | Weight (kg)

Health questions
These pertain to the **last 5 years** before insurance coverage began or before the benefit increase. Please also provide the details as requested for the questions you answered with «Yes».

Details

1. Were you fully or partially incapacitated at the beginning of the insurance or at the time when benefits increased? ☐ Yes ☐ No

Has a decision be reached on disability insurance (IV)? ☐ Yes ☐ No
Please include a copy of the IV decision if you have one. Otherwise, please include statements from the daily sickness benefits or accident insurance provider, if available.

2. Do you have any health impairment or damage as the result of an accident or illness? ☐ Yes ☐ No

Which | Since when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

3. Do you have or have you had one or several of the following health disorders or impairments: Arthritis, asthma, disease of the eye, bronchitis, high blood pressure, high cholesterol, heart disease, cancer, paralysis, multiple sclerosis, impaired sight or hearing that has **not** been corrected, psychological disorders or impairments, rheumatism, thyroid or glandular disorders, stroke, spine disorders, diabetes or illnesses, symptoms or disorders other than those listed here? ☐ Yes ☐ No

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

Which | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address) administering treatment

*** 1 = healed/all is well/treatment completed**
*** 2 = not healed/all is not well/still in treatment or under observation**

4. Did you miss work as a result of an accident or illness partially or fully for more than two weeks? ☐ Yes ☐ No

Why | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Why | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

5. Were you ever in the care of a physician, chiropractor or psychologist for more than 4 weeks, or do you require, take, or did you take, any medication, painkillers, sleeping pills, sedatives, or drugs regularly? ☐ Yes ☐ No

Why do you or did you require treatment/were you under observation | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

What medication, etc. | From when to when | How much per week

Why do you or did you require treatment/were you under observation | From when to when | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

What medication, etc. | From when to when | How much per week

6. Did you undergo any special medical examinations, such as check-ups, x-rays, ECG, HIV test, etc., **that produced not a normal result** (do not include results from genetic tests)? ☐ Yes ☐ No

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

7. Have you had an operation (inpatient or outpatient), or is an operation planned or has one been recommended? ☐ Yes ☐ No

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

Which | When | Recovered ☐ 1* | Not recovered ☐ 2*

Doctor/hospital (name and address)

8. Which doctor (also chiropractor, psychotherapist) is best able to offer information about your state of health?

Name | First name | Postcode and location

*** 1 = healed/all is well/treatment completed**

*** 2 = not healed/all is not well/still in treatment or under observation**

Additional information
for job changes

Were you insured under an occupational benefits plan with your previous employer? ☐ Yes ☐ No
If so, please provide us with the following information

Company or occupational benefits institution | Street, postcode and location

Is a health proviso currently in place from your previous pension fund? ☐ Yes ☐ No
(If yes, please include a copy)

Remarks

Declaration

I hereby authorize doctors, psychotherapists, physiotherapists, chiropractors, hospitals, accident and daily benefits insurers, and my previous occupational benefits institution to provide the medical services of AXA Life Ltd with information about my state of health and/or about my previous insurance coverage in connection with this insurance.

I am aware that this coverage depends on the accuracy of this declaration and that the foundation can withdraw from the contract under the statutory provisions if information contained herein proves incorrect.

Tax liability

The insured person hereby confirms accepting sole responsibility for notifying the relevant tax authorities and for meeting all tax liabilities that result from payments received.

Signature

Date | Signature

Please send to

AXA Life Ltd
P.O. Box 300
8401 Winterthur